

#	0041509	Report Period Beginning:	01/01/05	Ending:	12/31/05
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D. How many bed-hold days during this year were paid by the Department?

0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)

none

F. Does the facility maintain a daily midnight census? yes

YES ☐ NO ☒

YES ☐ NO ☒

Date started 1996

YES ☒ Date _____ NO ☐ **XX**

YES NO If YES, enter number
of beds certified _____ and days of care provided 3,441

Medicare Intermediary Mutual of Omaha

ACCRUAL	<input checked="" type="checkbox"/>	MODIFIED	<input type="checkbox"/>	CASH*	<input type="checkbox"/>
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Is your fiscal year identical to your tax year? YES ☐ NO ☐

*** All facilities other than governmental must report on the accrual basis.**

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	14,913	6,105	3,441	24,459	8
9	SNF/PED			0		9
10	ICF					10
11	ICF/DD					11
12	SC	0	0	0		12
13	DD 16 OR LESS					13
14	TOTALS	14,913	6,105	3,441	24,459	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) **62.05%**

*** All facilities other than governmental must report on the accrual basis.**

Facility Name & ID Number Heritage Manor-Carlinville # 0041509 Report Period Beginning: 01/01/05 Ending: 12/31/05

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	151,501	7,857		159,358		159,358	4,767	164,125			1
2	Food Purchase		116,593		116,593		116,593		116,593			2
3	Housekeeping	72,230	14,613		86,843		86,843	5	86,848			3
4	Laundry	42,111	12,933		55,044		55,044		55,044			4
5	Heat and Other Utilities			85,556	85,556		85,556	1,505	87,061			5
6	Maintenance	42,061	30,976	23,889	96,926		96,926	12,608	109,534			6
7	Other (specify):*											7
8	TOTAL General Services	307,903	182,972	109,445	600,320		600,320	18,885	619,205			8
	B. Health Care and Programs											
9	Medical Director			3,500	3,500		3,500		3,500			9
10	Nursing and Medical Records	1,121,066	55,484	10,332	1,186,882		1,186,882		1,186,882			10
10a	Therapy		222,640	260,798	483,438	(477,366)	6,072	236,720	242,792			10a
11	Activities	55,789	1,484		57,273		57,273		57,273			11
12	Social Services	19,852		3,509	23,361		23,361		23,361			12
13	CNA Training	4,525	1,743		6,268		6,268	1,694	7,962			13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,201,232	281,351	278,139	1,760,722	(477,366)	1,283,356	238,414	1,521,770			16
	C. General Administration											
17	Administrative	55,000			55,000		55,000	73,087	128,087			17
18	Directors Fees							5,426	5,426			18
19	Professional Services			204,110	204,110		204,110	(189,035)	15,075			19
20	Dues, Fees, Subscriptions & Promotions			81,408	81,408	(59,130)	22,278	(7,906)	14,372			20
21	Clerical & General Office Expenses	81,321	6,800	23,583	111,704		111,704	150,858	262,562			21
22	Employee Benefits & Payroll Taxes			326,833	326,833		326,833	39,265	366,098			22
23	Inservice Training & Education			765	765		765	1,234	1,999			23
24	Travel and Seminar			5,441	5,441		5,441	(3,442)	1,999			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			71,394	71,394		71,394	1,925	73,319			26
27	Other (specify):*			139	139		139	(89)	50			27
28	TOTAL General Administration	136,321	6,800	713,673	856,794	(59,130)	797,664	71,323	868,987			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,645,456	471,123	1,101,257	3,217,836	(536,496)	2,681,340	328,622	3,009,962			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			112,217	112,217		112,217	12,794	125,011			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			186,255	186,255		186,255	22,021	208,276			32
33	Real Estate Taxes			39,755	39,755		39,755		39,755			33
34	Rent-Facility & Grounds							6,608	6,608			34
35	Rent-Equipment & Vehicles			7,756	7,756		7,756	(506)	7,250			35
36	Other (specify):*											36
37	TOTAL Ownership			345,983	345,983		345,983	40,917	386,900			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers					477,366	477,366		477,366			39
40	Barber and Beauty Shops		216	6,084	6,300		6,300		6,300			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee					59,130	59,130		59,130			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		216	6,084	6,300	536,496	542,796		542,796			44
	GRAND TOTAL COST											
45	(sum of lines 29, 37 & 44)	1,645,456	471,339	1,453,324	3,570,119		3,570,119	369,539	3,939,658			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(2,164)	35		5
6	Rented Facility Space		34		6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation		30		9
10	Interest and Other Investment Income	(253)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax		2		13
14	Non-Care Related Interest		32		14
15	Non-Care Related Owner's Transactions		33		15
16	Personal Expenses (Including Transportation)		24		16
17	Non-Care Related Fees	(1,239)	20		17
18	Fines and Penalties				18
19	Entertainment	(13,498)	24		19
20	Contributions	(89)	27		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(5,193)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt		27		24
25	Fund Raising, Advertising and Promotional	(11,255)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(37)	23		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (33,728)		\$	30

OHF USE ONLY							
48		49		50		51	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	403,267		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 403,267		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ 369,539		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification.

(See instructions.)

		1	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
1	\$		1
2			2
3			3
4			4
5		(2,164)	35
6		0	34
7			7
8			8
9		0	30
10			32
11			11
12			12
13		0	2
14			32
15		0	33
16			24
17		(1,239)	20
18			18
19			24
20		(89)	27
21			21
22		(5,193)	19
23			23
24		0	27
25		(11,255)	20
26			26
27			27
28			28
29		(37)	23
30			30
31			31
32			32
33			33
34			34
35			35
36			36
37			37
38			38
39			39
40			40
41			41
42			42
43			43
44			44
45			45
46			46
47			47
48			48
49	Total	(19,977)	49

Summary A

12/31/05

[illegible]

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Attached						

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V			\$			\$	\$	1
2	V	10a	Adjustment for Related Organization						2
3	V								3
4	V	19	Adjustment for Related Organization	198,917	Heritage Enterprises, Inc.	100.00%		(198,917)	4
5	V								5
6	V	10a	Adjustment for Related Organization	222,118	GreenTree Pharmacy	100.00%	458,838	236,720	6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$ 421,035			\$ 458,838	\$ * 37,803	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐

YES

☐

NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	Dietary	\$	Heritage Enterprises, Inc.	100.00%	\$ 4,767	\$ 4,767	15
16	V	2	Food Purchase				0		16
17	V	3	Housekeeping				5	5	17
18	V	4	Laundry				0		18
19	V	5	Heat & Other Utilities				1,505	1,505	19
20	V	6	Maintenance				12,608	12,608	20
21	V	7	Other				0		21
22	V	9	Medical Director				0		22
23	V	10	Nursing & Medical Records				0		23
24	V	11	Activities				0		24
25	V	12	Social Service				0		25
26	V	13	Nurse Aide Training				1,694	1,694	26
27	V	14	Program Transportation				0		27
28	V	15	Other				0		28
29	V	17	Administrative				73,087	73,087	29
30	V	18	Directors Fees				5,426	5,426	30
31	V	19	Professional Services				15,075	15,075	31
32	V	20	Fees, Subscription, Promotions				4,588	4,588	32
33	V	21	Clerical & General Office Expenses				150,858	150,858	33
34	V	22	Employee Benefits & Payroll Taxes				39,265	39,265	34
35	V	23	Inservice Training & Education				1,271	1,271	35
36	V	24	Travel and Seminar				10,056	10,056	36
37	V	25	Other Admin. Staff Transportation				0		37
38	V	26	Insurance-Prop.Liab.Malpract				1,925	1,925	38
39	Total			\$			\$ 322,130	\$ * 322,130	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐

YES

☐

NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	27	Other	\$	Heritage Enterprises, Inc.	100.00%	\$	0	15
16	V	30	Depreciation					12,794	16
17	V	31	Amortization of Pre-Op & Org					0	17
18	V	32	Interest					22,274	18
19	V	33	Real Estate Taxes					0	19
20	V	34	Rent-Facility & Grounds					6,608	20
21	V	35	Rent-Equipment & Vehicles					1,658	21
22	V	36	Other					0	22
23	V	38	Medically Nec Transportation					0	23
24	V	39	Ancillary Service Centers					0	24
25	V	40	Barber and Beauty Shops					0	25
26	V	41	Coffee and Gift Shops					0	26
27	V	42	Other					0	27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	0	\$ * 43,334 39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Heritage Manor-Carlinville # 0041509 Report Period Beginning: 01/01/05 Ending: 12/31/05

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Susie Jefferson	Director	Management	15.86				Salary/BOD	\$ 16,493	Ln 17 & 18	1
2	Estate of Tom Jefferson			16.21				Salary/BOD	0	Ln 17 & 18	2
3	Craig Hart	Chairman	Management	31.95				Salary/BOD	18,495	Ln 17 & 18	3
4	Cheryl Lowney	Executive Vice Presi	Management	0.49		40	100.00	Salary/BOD	11,012	Ln 17 & 18	4
5	Steve Wannemacher	President	Management	0.42		40	100.00	Salary/BOD	14,351	Ln 17 & 18	5
6	Connie Hoselton	Sr Vice President	Management	0.27		40	100.00	Salary	7,081	Ln 17 & 18	6
7	Craig Ater	Sr Vice President	Management	0.34		40	100.00	Salary	7,936	Ln 17 & 18	7
8	Ben Hart	Vice President	Management	3.20		40	100.00	Salary	3,145	Ln 17 & 18	8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 78,513		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.

Facility Name & ID Number Heritage Manor-Carlinville # 0041509 Report Period Beginning: 01/01/05 Ending: 12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization Heritage Enterprises
Street Address 115 W. Jefferson
City / State / Zip Code Bloomington,IL
Phone Number ()
Fax Number ()

B. Show the allocation of costs below. If necessary, please attach worksheets.

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	1	Dietary	Beds	2,612	25	\$ 115,289	\$ 115,276	108	\$ 4,767	1
2	2	Food Purchase	Beds	2,612	25	7	0	108	0	2
3	3	Housekeeping	Beds	2,612	25	124	0	108	5	3
4	4	Laundry	Beds	2,612	25	0	0	108	0	4
5	5	Heat & Other Utilities	Beds	2,612	25	36,387	0	108	1,505	5
6	6	Maintenance	Beds	2,612	25	304,933	79,110	108	12,608	6
7	7	Other	Beds	2,612	25	0	0	108	0	7
8	9	Medical Director	Beds	2,612	25	0	0	108	0	8
9	10	Nursing & Medical Records	Beds	2,612	25	0	0	108	0	9
10	11	Activities	Beds	2,612	25	0	0	108	0	10
11	12	Social Service	Beds	2,612	25	0	0	108	0	11
12	13	Nurse Aide Training	Beds	2,612	25	40,976	40,976	108	1,694	12
13	14	Program Transportation	Beds	2,612	25	0	0	108	0	13
14	15	Other	Beds	2,612	25	0	0	108	0	14
15	17	Administrative	Beds	2,612	25	1,767,611	1,767,611	108	73,087	15
16	18	Directors Fees	Beds	2,612	25	131,223	0	108	5,426	16
17	19	Professional Services	Beds	2,612	25	364,592	0	108	15,075	17
18	20	Fees, Subscription, Promotions	Beds	2,612	25	110,958	0	108	4,588	18
19	21	Clerical & General Office Expense	Beds	2,612	25	3,648,522	3,309,912	108	150,858	19
20	22	Employee Benefits & Payroll Taxes	Beds	2,612	25	949,625	0	108	39,265	20
21	23	Inservice Training & Education	Beds	2,612	25	30,747	0	108	1,271	21
22	24	Travel and Seminar	Beds	2,612	25	243,204	0	108	10,056	22
23	25	Other Admin. Staff Transportation	Beds	2,612	25	0	0	108	0	23
24	26	Insurance-Prop.Liab.Malpract	Beds	2,612	25	46,560	0	108	1,925	24
25	TOTALS					\$ 7,790,758	\$ 5,312,885		\$ 322,130	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6		7	8	9	10		
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense			
		YES	NO				Original	Balance						
	A. Directly Facility Related													
	Long-Term													
1	LsSalle National Bank		xx	Mortgage	4640 plus Int	01/15/99	\$	2,409,913	01/15/06	variable	\$	158,337	1	
2	LsSalle National Bank		xx	Mortgage								9,813	2	
3													3	
4													4	
5													5	
	Working Capital													
6	Central Office Allocation		xx	Working Capital								18,105	6	
7	Central Office Allocation		xx	Working Capital									7	
8													8	
9	TOTAL Facility Related						\$	2,409,913				\$	186,255	9
	B. Non-Facility Related*													
10	Interest Income											(253)	10	
11													11	
12	Central Office Allocation											22,274	12	
13													13	
14	TOTAL Non-Facility Related						\$					\$	22,021	14
15	TOTALS (line 9+line14)						\$	2,409,913				\$	208,276	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ Line #

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

		Important , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1. Real Estate Tax accrual used on 2004 report.				\$	40,0601
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)				\$	38,9342
3. Under or (over) accrual (line 2 minus line 1).				\$	(1,126)3
4. Real Estate Tax accrual used for 2005 report. (Detail and explain your calculation of this accrual on the lines below.)				\$	40,8814
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)				\$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)				\$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.				\$	39,7557
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		2000	32,590	8	
		2001	28,390	9	
		2002	32,706	10	
		2003	35,898	11	
		2004	38,496	12	
				13	FROM R. E. TAX STATEMENT FOR 2004 \$13
				14	PLUS APPEAL COST FROM LINE 5 \$14
				15	LESS REFUND FROM LINE 6 \$15
				16	AMOUNT TO USE FOR RATE CALCULATION \$16

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.

2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates RE: 2004 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2004 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2004.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2004 real estate tax bill to the Department of Public Aid, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2005 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2004 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Heritage Manor-Carlinville COUNTY Macoupin

FACILITY IDPH LICENSE NUMBER 0041509

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE () FAX #: ()

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2004 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2004.

(A)	(B)	(C)	(D)
			<u>Tax</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Applicable to</u>
			<u>Nursing Home</u>
1. 12-000-264-02	Heritage Manor-Carlinville	\$ 38,934.00	\$ 38,934.00
2.		\$	\$
3.		\$	\$
4.		\$	\$
5.		\$	\$
6.		\$	\$
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$ 38,934.00	\$ 38,934.00

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the original 2004 tax bills which were listed in Section A to this statement. Be sure to use the 2004 tax bill which is normally paid during 2005.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 14,527 B. General Construction Type: Exterior brick/wood Frame wood Number of Stories 1

C. Does the Operating Entity? [xx] (a) Own the Facility [] (b) Rent from a Related Organization. [] (c) Rent from Completely Unrelated Organization.
(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [xx] (a) Own the Equipment [] (b) Rent equipment from a Related Organization. [] (c) Rent equipment from Completely Unrelated Organization.
(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.)
List entity name, type of business, square footage, and number of beds/units available (where applicable).
none

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [] YES [xx] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:
3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1				\$ 32,017	1
2					2
3	TOTALS			\$ 32,017	3

XI. OWNERSHIP COSTS (continued)											
B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.											
	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	108				\$ 3,265,145	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Heritage Manor Sign			1996	2,176						9
10	Architect Fees			1996	2,387						10
11	Laundry Room Electrical Repair			1996	3,019						11
12											12
13											13
14	Special Care Unit -- Remodel			1997	30,884						14
15											15
16	Remodel-- Alzheimer Wing			1998	78,813						16
17	A/C Unit			1998	950						17
18	Life Safety Improvements			1998	7,351						18
19	Shower Room Remodel			1998	2,811						19
20	Roof Replacement			1998	92,246						20
21											21
22	Door Alarm			1999	2,317						22
23	Smoke Damperer			1999	498						23
24	Water System			1999	8,115						24
25	Interior Painting--Material and Labor			1999	6,892						25
26	Shower Room Remodel			1999	2,453						26
27	Water Heater			1999	4,253						27
28											28
29											29
30											30
31											31
32											32
33											33
34	C/O Allocation							12,794	12,794		34
35	Book Depreciation					97,484		97,484		870,988	35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Water Softener	2000	\$ 3,802	\$		\$	\$		37
38	Shower room Remodel ---Material and Labor	2000	3,608						38
39	A/C Rooftop Unit	2000	12,490						39
40	Pipe --Hallway Floor	2000	1,920						40
41									41
42	Electric Heater	2001	4,700						42
43									43
44	A/C Rooftop Unit-(remove)	2002	(12,490)						44
45	Heat / Cool Unit	2002	8,969						45
46	Floor Coverings	2002	6,638						46
47	Roof top unit	2002	4,995						47
48	Roof top unit	2002	2,918						48
49									49
50	Floor coverings	2003	11,232						50
51	Resurface parking lot	2003	25,786						51
52	A/C unit	2003	11,167						52
53	Dishwasher	2003	3,880						53
54	Boiler	2003	1,978						54
55	Backflow unit	2003	740						55
56	Heat / Cool Unit	2003	5,607						56
57									57
58	Hot Water Pump	2004	750						58
59	Heat / Cool Unit	2004	4,485						59
60	Booster Heater	2004	2,261						60
61	Door Closer	2004	578						61
62	A/C Unit	2004	1,101						62
63	Roof top unit	2004	3,504						63
64	Electric Heater	2004	13,454						64
65	Secure Care System	2004	3,053						65
66	Ansul System	2004	1,685						66
67									67
68	Wallguard/Wallcoverings								68
69	Carpet								69
70	TOTAL (lines 4 thru 69)		\$ 3,639,121	\$ 97,484		\$ 110,278	\$ 12,794	\$ 870,988	70

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$3,639,121	\$97,484		\$110,278	\$12,794	\$870,988	1
2									2
3	Window Replacement	2005	371						3
4	HVAC	2005	10,165						4
5	Rooftop A/C	2005	8,997						5
6	Water Storage Tank	2005	4,456						6
7	Rooftop Heater	2005	3,425						7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$3,666,535	\$97,484		\$110,278	\$12,794	\$870,988	34

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$388,220	\$15,433	\$15,433	\$		\$360,656	71
72	Current Year Purchases	24,184						72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$412,404	\$15,433	\$15,433	\$		\$360,656	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$4,110,956	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$112,917	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$125,711	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$12,794	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$1,231,644	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions.
- ☐ YES☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease
-

9. Option to Buy:
- ☐ YES☐ NO
- Terms:
- *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?
- ☐ YES☐ NO
16. Rental Amount for movable equipment: \$ 7,250
- Description:

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:
- Beginning
- Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2006	\$
13.	/2007	\$
14.	/2008	\$

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES
☐ NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM
IN OTHER FACILITY
COMMUNITY COLLEGE
HOURS PER CNA

3. CLINICAL PORTION:

IN-HOUSE PROGRAM
IN OTHER FACILITY
HOURS PER CNA

B. EXPENSES

		ALLOCATION OF COSTS (d)			
		1	2	3	4
		Facility		Contract	Total
		Drop-outs	Completed		
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies		1,743		1,743
3	Classroom Wages (a)		4,525		4,525
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$ 6,268	\$	\$ 6,268
10	SUM OF line 9, col. 1 and 2 (e)	\$ 6,268			

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

\$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$ 99,637	\$		\$ 99,637	1
2	Licensed Speech and Language Development Therapist		hrs			35,463			35,463	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs			107,170	522		107,692	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts				458,838		458,838	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):					18,528			18,528	13
14	TOTAL			\$		\$ 260,798	\$ 459,360		\$ 720,158	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

This report must be completed even if financial statements are attached.

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 11,634	\$	1
2	Cash-Patient Deposits	27,589		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	453,031		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	14,220		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	(1,961,831)		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ (1,455,357)	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	32,017		13
14	Buildings, at Historical Cost	3,666,534		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	412,405		16
17	Accumulated Depreciation (book methods)	(1,231,644)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):	31,069		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 2,910,381	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,455,024	\$	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 80,731	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	27,589		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	200,969		30
31	Accrued Taxes Payable (excluding real estate taxes)	2,239		31
32	Accrued Real Estate Taxes(Sch.IX-B)	40,881		32
33	Accrued Interest Payable	15,015		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 367,424	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	2,409,913		40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 2,409,913	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,777,337	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (1,322,313)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,455,024	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (1,061,430)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (1,061,430)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(260,883)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (260,883)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (1,322,313)	24 *

* This must agree with page 17, line 47.

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required

classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

1			
	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 3,269,184	1
2	Discounts and Allowances for all Levels	(1,014,833)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,254,351	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	631,444	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 631,444	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements	8,387	11
12	Gift and Coffee Shop	1,559	12
13	Barber and Beauty Care	8,781	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	404,461	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 423,188	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	253	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 253	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 3,309,236	30

2			
	Expenses	Amount	
	A. Operating Expenses		
31	General Services	600,320	31
32	Health Care	1,760,722	32
33	General Administration	856,794	33
	B. Capital Expense		
34	Ownership	345,983	34
	C. Ancillary Expense		
35	Special Cost Centers	6,300	35
36	Provider Participation Fee		36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 3,570,119	40
41	Income before Income Taxes (line 30 minus line 40)**	(260,883)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (260,883)	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,800	1,935	\$ 45,433	\$ 23.48	1
2	Assistant Director of Nursing	1,730	1,950	33,071	16.96	2
3	Registered Nurses	2,983	3,258	60,498	18.57	3
4	Licensed Practical Nurses	12,860	14,256	270,805	19.00	4
5	CNAs & Orderlies	64,543	69,177	691,394	9.99	5
6	CNA Trainees	500	500	4,525	9.05	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,718	1,888	19,865	10.52	8
9	Activity Director					9
10	Activity Assistants	5,468	5,842	55,789	9.55	10
11	Social Service Workers	1,840	1,878	19,852	10.57	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	16,804	17,839	151,501	8.49	15
16	Dishwashers					16
17	Maintenance Workers	3,482	3,687	42,061	11.41	17
18	Housekeepers	11,028	11,556	72,230	6.25	18
19	Laundry	3,517	3,708	42,111	11.36	19
20	Administrator	1,900	2,080	55,000	26.44	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	6,174	6,742	81,321	12.06	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	136,347	146,296	\$ 1,645,456 *	\$ 11.25	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant		\$ 0		35
36	Medical Director		3,500		36
37	Medical Records Consultant		7,583		37
38	Nurse Consultant				38
39	Pharmacist Consultant		2,166		39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant		3,509		45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 16,758		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	0	\$ 0		50
51	Licensed Practical Nurses	0	0		51
52	Certified Nurse Assistants/Aides	0	0		52
53	TOTAL (lines 50 - 52)		\$		53

Facility Name & ID Number	Heritage Manor-Carlinville
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XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes				F. Dues, Fees, Subscriptions and Promotions			
Name		Function	Ownership %	Amount	Description		Amount	Description		Amount	
Karla Smith		Admin		\$ 55,000	Workers' Compensation Insurance		\$ 38,424	IDPH License Fee		\$ 0	
					Unemployment Compensation Insurance		29,046	Advertising: Employee Recruitment		1,700	
					FICA Taxes		125,877	Health Care Worker Background Check			
					Employee Health Insurance		125,985	(Indicate # of checks performed)		450	
					Employee Meals			Central Office Allocation		4,588	
					Illinois Municipal Retirement Fund (IMRF)*			Promotional Advertising		4,228	
					Employee Hepatitis Vaccine		0	Public Relations		7,027	
					Employee Benefits -		7,501	Dues and Subscriptions		8,873	
					Employee Benefits - central office		39,265	License and Fees		0	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)				\$ 55,000				Less: Public Relations Expense		(7,027)	
B. Administrative - Other								Non-allowable advertising		(1,239)	
Description				Amount				Yellow page advertising		(4,228)	
				\$				TOTAL (agree to Sch. V, line 20, col. 8)		\$ 14,372	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)				\$	TOTAL (agree to Schedule V, line 22, col.8)		\$ 366,098				
C. Professional Services					E. Schedule of Non-Cash Compensation Paid to Owners or Employees				G. Schedule of Travel and Seminar**		
Vendor/Payee		Type		Amount	Description		Line #	Amount	Description		Amount
Heritage Enterprises		Mgt Fees		\$ 198,917				\$	Out-of-State Travel		\$
				0							
				0							
									In-State Travel		
											2,477
											224
									Seminar Expense		2,740
											(13,498)
											10,056
				0							
Legal --Adjusted to zero				5,193					Entertainment Expense		(
				0					(agree to Sch. V, line 24, col. 8)		
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$2500 attach copy of invoices.)				\$ 204,110	TOTAL			\$	TOTAL		\$ 1,999

*** Attach copy of IMRF notifications**

****See instructions.**

(See instructions.)

[illegible]

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union?

no

(2) Are there any dues to nursing home associations included on the cost report?

yes

If YES, give association name and amount. Illinois Healthcare Association

(3) Did the nursing home make political contributions or payments to a political action organization?

yes

If YES, have these costs been properly adjusted out of the cost report?

yes

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year?

no

If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases?

yes

What was the average life used for new equipment added during this period?

7 years

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 5,000 Line 10

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports?

yes

If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement?

no

If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement?

YES

xx

NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO xx

If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 59,130

This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee?

no

If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V?

yes

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B?

yes

For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0

Has any meal income been offset against related costs?

yes

Indicate the amount. \$ 577

(16) Travel and Transportation

a. Are there costs included for out-of-state travel?

no

If YES, attach a complete explanation.

b. Do you have a separate contract with the Department to provide medical transportation for residents?

no

If YES, please indicate the amount of income earned from such a program during this reporting period. \$

c. What percent of all travel expense relates to transportation of nurses and patients?

100%

d. Have vehicle usage logs been maintained?

yes

e. Are all vehicles stored at the nursing home during the night and all other times when not in use?

yes

f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?

yes

g. Does the facility transport residents to and from day training?

no

Indicate the amount of income earned from providing such transportation during this reporting period. \$

(17) Has an audit been performed by an independent certified public accounting firm?

yes

Firm Name: Sulaski & Webb

The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached?

No

If no, please explain. Not available

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V?

yes

(19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report?

yes

Attach invoices and a summary of services for all architect and appraisal fees.

BANK CHARGE PRIVATE & VA -506.69
ROYALTY ASSESSMENT TAX INCOME
BANK CHARGE-IFA 0
BANK CHARGE-MEDICARE 0
DAY CHARGING-CARE
LIGHT NURSING-CARE -56,393
MEDIUM NURSING-CARE
HEAVY NURSING-CARE
WELDED NURSING-CARE
NURSING SUPPLIES PRIVATE -102,488
NURSING SUPPLIES-PPA
NURSING SUPPLIES MED-PT &
NURSING SUPPLIES MED-PT &
DRUGS -489,441
DRUGS-OTHER -431,444
PT DRUGS
PT MEDICARE PART A
PUBLIC AD ASSESSMENT INC
LABORATORY INCOME
DRUGS/HOT PRIVATE
DRUGS/HOT IFA
DRUGS/HOT MED PART A
DRUGS/HOT MED PART A
PA ADD-ON
MEDICARE PART A DISCOUNT
MEDICARE PART A DISCOUNT
ASSESSMENT TAX EXPENSE
ROYALTY INCOME 0
REACTIVITY SHOP -4,791
ACTIVITY SHOP INCOME 0
VENUE INCOME EXPENSE -1,559
MANAGEMENT FEES
EQUIPMENT RENTAL -66,274
EQUIPMENT TRANSPORTATION 0
GENERAL & ADMINSTR WAGES 78,737 81,221
ADMINISTRATOR WAGES 55,000 55,000
VACATION & SICK -GSA 2,048
EMPLOYEE BENEFITS 1,041 1,041
EMPLOYEE BENEFITS VACATION 0
EMPLOYEE BENEFITS-OTHER WAG 0
EMPLOYEE BENEFITS-OTHER WAG 0
OTHER FORMS FEES
OTHER FORMS FEES 1,735 6,889
TELEPHONE 23,341 23,341
TRAVELING & EMPLOYEE TRAVEL 565 565
GENERAL TRAVEL 2,477 5,441
MEAL EXPENSE FOR TRAVEL 224
EDUCATION & RESEARCH 2,140
HOTEL/RESTAURANT/ADVERTISING 1,100 81,408
PROFESSIONAL ADVERTISING 2,100
PUBLIC RELATIONS 7,027
LUNCH & DINNER 84,170
GUEST & SUBSCRIPTIONS 1,473
CONFERENCES 89
PROFESSIONAL FEES 5,183 204,110
MEDICAL CONSULTING 2,500 2,500
UTILIZATION REVIEW 0
OTHER PROFESSIONAL FEES 0
MEDICAL & DENTAL CONSULT 2,500 3,500
PHARMACY FEES 2,146
SOC SERVICE CONSULT 2,500
TV RENTAL 2,796 139
INCOME TAXES
BACKGROUND CHECKS 450
FEDERAL TAXES 149,224
FEDERAL TAXES-ADMINISTR 1,796
GROSS INDEMNITY 123,048
LIABILITY INSURANCE 71,394 71,394
INSURANCE-OWNERS
WORKERS COMPENSATION 38,424
CENTRAL OFFICE FEES 109,017
MAIL FEES 0
LOST ITEM REIMBURSEMENTS 0
MAILS-ADMINISTR 0
MAILS-ADMINISTR 0
LEASED EQUIPMENT 1,088 7,736
MAINTENANCE & REPAIRS 48,051 42,091
MAINTENANCE DECK & VAC 2,047
ELECTRIC 84,475 85,556
NATURAL GAS 16,784
HEATING & COOLING OIL 16,784
WATER & SEWER 16,205
TRANSPORTATION 1,000 23,889
PROPERTY TAX REIMBURSEMENT 1,000
GENERAL REPAIR & MAINT 22,622 20,076
MAINTENANCE CONTRACTS 26,361
DIETARY WAGES 144,486 151,501
DIETARY DECK & VAC 1,000
SALES TAX 117,179 116,793
NURSING SERVICES 2,400
DIETARY REPLACEMENT 785 7,887
NURSING SERVICES 2,400
DIETARY REPLACEMENT 785
MAIL CREDIT 577
LAUNDRY WAGES 39,711 42,111
LAUNDRY DECK & VAC 2,040
LAUNDRY REPLACEMENT 6,031 10,533
LAUNDRY REIMBURSEMENT 4,000
LAUNDRY WAGES 69,274 73,186
HOUSEKEEPING DECK & VAC 1,054
HOUSEKEEPING SUPPLIES 0 16,653
HOUSEKEEPING SUPPLIES-PPA 14,653 1,031,666
RN WAGES-MEDICARE 57,488
RN WAGES-NON-MEDICARE 61,433
ADN 23,071
RN WAGES-MEDICARE 57,488
RN WAGES-NON-MEDICARE 294,252
LPN WAGES-MEDICARE 294,252
LPN WAGES-NON-MEDICARE 26,553
ADE WAGES-MEDICARE 625,191
ADE WAGES-NON-MEDICARE 56,267
CONTRACT NURSES-RN 0
CONTRACT NURSES-LPN 0
CONTRACT NURSES-ADN 0
NURSING TRAVEL WAGES 4,425 4,425
NURSE AID TRAINING EXP 1,743 1,743
NURSE AID TRAINING-OTHER 4,425
NURSE WAGES 19,084
NURSE DECK & VAC 39
NURSING SUPPLIES 49,668 55,484
NURSING SUPPLIES 4,775
REPLACEMENT NURSING 1,484
NURSING OTHER 893 10,333
DRUG PURCHASES 113,337 222,449
DRUG PURCHASES-OTHER 70,481
LABORATORY SERVICES 18,338 205,798
HOME HEALTH DECK & VAC
HOME HEALTH EXPENSES 53,766 55,799
ACTIVITIES DECK & VAC 2,013
ACTIVITIES SUPPLIES 1,484 1,484
ACTIVITIES FEES 0 0
PT DECK & VACATION
PT FEES 107,179
PT FEES 622
SOCIAL SERVICE WAGES 14,312 10,852
SOCIAL SERVICE DECK & VAC 721
SOCIAL SERVICE EXPENSES 0 0
OTHER 99,607
SOCIAL THERAPY FEES 0 0
SOCIAL THERAPY FEES 14,461
HEALTHCARE WAGES
HEALTHCARE DECK & VAC 0
HEALTHCARE FEES 6,086 6,086
HEALTHCARE SUPPLIES 284 284
VACATION COMPENSATION
VAC DECK & VAC
VAC DECK & VAC 35
RENT 0
PROPERTY EXPENSE 174,442 186,235
PROPERTY EXPENSE 112,177 112,177
LOAN FEE AMORTIZATION 5,815
PROPERTY INCOME 553
MEDICARE OPERATING INCOME 0
INCOME TAXES 3,561,479 3,571,119
3,561,479 3,571,119
(NET INCOME)
0

					2,612	108	3,471,750	71,391,262		
Name	Title	Function	Total Pay	usted by Mgmt F	total # Bed	acility # Beon-Nursing Hor	Nursing Home	This Facility		
### Susie Jefferson	Director	Managem	418,245	418,245		19,396	398,849	16,493		
### Tom Jefferson	Secretary	Managem	0	0		0	0	0		
### Craig Hart	Chairman	Managem	469,049	469,049		21,752	447,297	18,495		
### Cheryl Lowney	Executive Vice Presic	Managem	279,290	279,290		12,952	266,338	11,012		
### Steve Wannemache	President	Managem	363,969	363,969		16,879	347,090	14,351		
### Connie Hoselton	Sr Vice President	Managem	179,584	179,584		8,328	171,256	7,081		
### Craig Ater	Sr Vice President	Managem	201,279	201,279		9,334	191,945	7,936		
Ben Hart			79,758	79,758		3,699	76,059	3,145		
13			1,991,174	1,991,174			1,898,834	78,513		